Maryland Health Care Reform Coordinating Council

Public Health, Safety Net, and Special Populations Workgroup

October 31, 2010

Introduction and Charge to the Workgroup

The Patient Protection and Affordable Care Act of 2010 (ACA), commonly referred to as federal health reform, has significant potential to transform Maryland's health care delivery system. More Marylanders will have access to affordable health insurance through an expansion of Medicaid and new federal subsidies will help others purchase health insurance through new Health Insurance Exchanges. The federal government will develop an Essential Benefit Plan that will shape what health care services are covered by health insurers. The ACA creates new funding opportunities and demonstration projects to make changes to the health care delivery system to improve health outcomes and promote wellness, prevention, and health equity. These shifts in coverage status and other changes will affect the traditional role and functions of safety net programs for special populations as well as the public health infrastructure. Proactive planning to shape the future of the health care safety net and services for special populations in Maryland in anticipation of these changes is critical.

The Public Health, Safety Net, and Special Populations workgroup was charged with addressing the following questions:

> (1) How will Maryland ensure that populations that remain without adequate insurance coverage obtain the health care they need?
> (2) How will the safety net prepare for the likely changes in benefits that are covered by commercial or public insurers?
> (3) How should the public health infrastructure leverage the demonstration projects, grant opportunities, and other features of reform to augment its resources, increase its effectiveness, and enhance its impact?
> (4) What changes should occur in how behavioral health services are provided and how will these changes interface with new mental health parity rules and other changes in insured benefits?
> (5) How will Maryland facilitate the coordination of safety net services in the reformed health care system while identifying both persistent and new unmet needs and coordinating safety net care delivery?
> (6) What should be expected of traditional safety net providers in an environment in which more individuals have insurance coverage, and how can the capacity of these providers be leveraged and fostered?
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> (HCRCC Interim Report, 2010, p.17-18).

Workgroup Process

The workgroup sought input from the public through a series of public meetings and by disseminating materials via the Health Care Reform Coordinating Council (HCRCC) website (www.healthreform.maryland.gov). The Public Health, Safety Net, and Special Populations workgroup was co-chaired by Delegate James Hubbard, House Health and Government Operations Committee, Fran Phillips, Deputy Secretary, Department of Health and Mental

Hygiene - Public Health Services, and Renata Henry, Deputy Secretary, Department of Health and Mental Hygiene - Behavioral Health and Disabilities. There was no assigned membership; in an effort to be as inclusive as possible, participation in the workgroup was open to any interested party. Specifically, this workgroup requested public input regarding options to consider in designing a comprehensive, proactive approach to integrating public health infrastructure and initiatives, behavioral health services and supports, and health care safety net and services for special populations in Maryland. This report summarizes the public input and outlines the common themes identified in the workgroup process.

The workgroup met three times between September 2010 and October 2010. The goals of the first meeting were to review the charge, the work plan, and provide background information on newly insured, the uninsured, and existing community health resources. A panel of speakers provided an overview of safety net as well as the behavioral health services system. The goals of the second meeting were to explore issues related to public health and special populations and to receive public comment. Written comments were also accepted via the HCRCC website. The third meeting was devoted to gaining feedback on the white paper of options based on public comment.

Issues for Workgroup

This section provides background information and summarizes public comments around the main issues addressed by the workgroup. Although this section is divided into three categories, there is significant overlap among these issues as the public health infrastructure and the safety net are essential components of caring for special populations and promoting health equity.

Public Health

Public health serves the health of a community as a whole. It encompasses health promotion, disease prevention, health education, community coalition building, environmental health, epidemiology, public health surveillance, and gap-filling clinical services not available through private providers. Over 80% of the increase in life expectancy experienced in the 20th century is the direct result of public health interventions (Improving Health: Measuring Effects of Medical Care. Milbank Quarterly, 1994).

Public health is the science and practice of protecting, promoting, and improving the health and well-being of individuals and communities through control of communicable diseases, application of sanitary measures, monitoring of environmental hazards, health education and prevention, addressing health disparities, and policy development. Public health interventions, through organized community efforts aimed at the prevention of disease and the promotion of health, assure conditions in which people can be healthy [Institute of Medicine]. Federal, state, territorial and local governmental agencies, working with public and private entities, comprise the nation's broad public health system. Collectively, the system prevents disease, injury and disability, protects against environmental hazards, promotes physical and mental health,

responds to disasters and emerging diseases, and ensures access to healthcare services. Within this broader public health system, governmental public health – composed of federal, state, and local health agencies – carries out an exceptional and fundamental role. It is uniquely accountable to the public and elected representatives for the responsible use of tax dollars that fund its activities. The U.S. Constitution reserves to the states the primary authority and legal responsibility to protect the health of the population within their borders. Still, no single component of the government's public health system can function to maximum effectiveness without the other components. Local health departments are one of these governmental entities.

The major elements of ACA expand health insurance coverage and care through changes to the health care financing and delivery system. These changes affect how and whether individuals receive health care services. These reforms affect public health, but do not replace it. The workgroup discussion demonstrated a consensus that the public health infrastructure, including Local Health Departments (LHDs) and population-based programs, provide unique functions that will not be replaced by the health insurance coverage aspects of reform.

The core functions of public health are:

1. Assessment:
    i. Monitor health status to identify community health problems;
    ii. Investigate community health problems and hazards;
    iii. Evaluate effectiveness, accessibility, and quality of health services;
2. Policy Development:
    iv. Develop policies and plans that support individual and community health efforts;
    v. Enforce laws and regulations that protect health and ensure safety;
    vi. Develop new insights and innovative solutions to health problems;
3. Assurance:
    vi. Link people to needed personal health services and assure the provision of health care when otherwise unavailable, including the provision of gap-filling services;
    viii. Assure a competent public health and personal health care workforce;
    ix. Inform, educate, and empower people about health issues; and
    x. Mobilize community partnerships to identify and solve health problems.

To that end, the ACA provides for an array of initiatives to improve quality and encourage prevention and wellness that are particular to public health. The Prevention and Public Health Fund is a historic investment in public health programs that prevent illness and injury before they occur, thereby resulting in significantly lower health care costs. For example, the Fund authorizes funding for the Community Transformation Grant Program which will provide competitive grants to reduce chronic disease rates, address health disparities, and develop a stronger evidence base of effective prevention programming (HCRCC Interim Report, 2010, p.2). However, it remains unclear the extent to which federal funds will actually be appropriated, how Maryland will fare in competing for these funds, and to what extent Community

Transformation and other ACA funds will reach all LHDs.

The ACA also provides the opportunity for significant investment in training programs to increase the number of primary care doctors, nurses, and other public health care professionals in an effort to improve access to affordable health care. Other funding opportunities include the establishment of a public health workforce loan repayment program, training for mid-career professionals in public health or allied health, expanded public health fellowship training programs, and training for general, pediatric, and public health dentistry (HCRCC Interim Report, 2010, p. 2). The ACA also includes provisions for research on optimizing the delivery of public health services and understanding health disparities.

One of the themes that emerged from comments was that public health and LHDs have an important role with unique community-based resources and expertise. Therefore, LHDs should be a fundamental part of strategic planning efforts to ensure that all Marylanders receive appropriate health services. Some public comments focused on the need for LHDs to be well represented in both future statewide health reform oversight activities and the development and monitoring of performance measures. Other comments focused on integrating population measures into all workgroup activities.

A recommendation was made to develop a strategic plan that integrates and coordinates the work of LHDs, community health centers, Federally Qualified Health Centers, school-based health clinics, and community-based organizations. It was also noted that not all jurisdictions have community health centers or community-based organizations and that strategic planning efforts should include all providers, not just those that receive grant and charity support. This plan should address how local providers can reach all segments of the population, including special populations, the uninsured, and the newly insured. Particular attention should be paid to gaining input from populations who experience health disparities. It was recommended that the HCRCC, or a successor oversight group, convene a diverse group of representatives to develop this strategic plan.

The role of information technology (IT) in public health was raised. Some comments related to eligibility and enrollment into Medicaid and Exchanges, and others related to Health Information Exchange – both are issues for other workgroups. The antiquated and duplicative IT systems throughout the sectors of public health were identified as barriers to coordination and effective care. It was also noted that while improvements to the state's IT systems will be expensive at the outset, they would likely result in long-term savings. Comments urged continued efforts to support LHDs in grant processes to support health IT innovation and implementation.

Finally, budget reductions and staff shortages were cited as serious barriers for LHDs in fulfilling their unique mission. Comments urged Maryland to pursue funding opportunities through ACA's Prevention and Public Health Fund and Community Transformation Grant Program. Others advocated for greater flexibility in current State funding, recognizing that the

current specific funding categories for LHDs do not reflect the unique needs of local areas and prevent local health departments from making more locally coordinated and allocated resource decisions. Finally, others supported funding for the State's tobacco prevention and cessation program.

Additional comments focused on the opportunities for the fields of Aging and Public Health to collaborate to develop the definition of primary prevention for seniors. Another area of concern was that policy considerations on reducing teen pregnancy should not be overwhelmed by the controversial issue of abortion. Other suggestions were made that the focus on primary care and prevention under health reform is an opportunity to include issues such as food security, environmental hazards, housing and workplace conditions, and violence in a comprehensive plan to improve the overall health of the people of Maryland.

Safety Net

The workgroup was charged with considering two different issues related to the safety net. First, how Maryland should ensure that populations without adequate health insurance get the health care they need; and second, how the role of traditional safety net providers may evolve under health reform.

Access for Remaining Uninsured

It has been estimated that when ACA is fully implemented, Maryland's uninsured rate will be reduced by half (from 14.0% to 6.7% by 2017) [HCRCC Interim Report, 2010]. These shifts in coverage status and other changes will affect the traditional role and functions of safety net providers and programs. The workgroup recognized that even after full implementation over 400,000 Marylanders are estimated to remain uninsured either by choice or circumstance and agreed that Maryland should maintain support for programs that serve uninsured individuals. Further, the Massachusetts' experience of increased emergency room use following coverage expansion was cited as an example of the potential of what might be expected in Maryland. The workgroup was cautioned that funding for safety net programs or providers should not be reduced until it is clear that the private sector has demonstrated a commitment to and capacity for serving the existing and newly insured. Some suggested that, at a minimum, there should be a period of transition built in that ensures continuity of care until new systems demonstrate functionality and sustainability.

Additional comments focused on how to improve care delivery for this group who will remain uninsured. Current models were discussed to improve care management through the provision of navigators that help coordinate follow-up care for uninsured individuals. Patient navigators and integrated primary care networks hold the promise of improving outcomes and reducing emergency department and hospital admissions due to unmanaged care. The workgroup

recognized that an effective and integrated infrastructure, such as patient navigators or case managers, is important to the success of current models.

Coverage of Special Services

Some individuals have health care needs that are not met by traditional health insurance products. Today, many of these individuals rely on safety net providers and programs to get the care they need. It is unclear whether or how health reform will address this issue. ACA requires the federal government to define Essential Health Benefits to be covered by all health plans offered through the Health Exchange. States may require additional benefits, but must fund the marginal cost of additional services. Comments expressed concern about access to a number of services that may be likely to fall outside the federal Essential Benefit Package, including adult dental care; wraparound services to prevent institutionalization; Rare and Expensive Case Management Programs (REM); interpreter services (foreign languages and sign language); and other wrap around services. Federal policy decisions about the essential benefits will be important to understand before decisions about gap filling safety net programs can be made.

The workgroup recognized the critical importance of Medicaid's current comprehensive benefit package, particularly for individuals with disabilities or other special needs. With uncertainty about the federal benefits requirements, other comments urged that Maryland maintain the full Medicaid benefit package for the Medicaid expansion under a Secretary-approved benchmark option.

Role of Safety Net Providers

The Institute of Medicine defines safety net providers as "providers that deliver a significant level of health care to uninsured, Medicaid, and other vulnerable patients." (IOM, America's Health Care Safety Net: Intact but Endangered, June 2000). Maryland has a broad network of safety net providers. Public comments maintained that Maryland should build on the strengths that already exist and also offered examples of safety net providers that include community health centers, school-based health centers, LHDs, behavioral health providers, emergency room departments and other community-based organizations. Today, these safety net providers are an important source of health care for the uninsured as well as for many with health insurance. Under health reform, safety net providers will continue to be an important source of care for both the insured and uninsured. Some individuals will likely move in and out of Medicaid and Exchange products and their continuity of care is dependent upon safety net providers participating in both Medicaid and Exchange products.

There was consensus that as more individuals gain access to health insurance and services previously provided to the uninsured on a sliding fee scale are now reimbursable, the traditional business model and operational practices of many safety net providers may need to change. Safety net providers may need to implement or enhance their IT systems to ensure that they are able to bill public health and commercial insurance networks for services provided. This

transition may present enormous challenges for many safety net providers, and it was suggested that the State may want to consider providing technical assistance and other supports to safety net providers as they undergo this transition. The Community Health Resources Commission was recognized as being capable and well positioned to provide this support. The following specific items were raised as potential areas for assistance: (1) IT/billing capacity; (2) grant writing; (3) an 'incubating' function that positions safety net providers to tap into new resources now available under reform; (4) GIS mapping services to better match supply and demand and identify gaps in service delivery, and (5) promoting and providing resources for cultural, linguistic and health literacy competency.

Some urged that the State ensure sustainability of the non-profit safety net programs after reform and others urged the State to continue funding for safety net providers during the transition period as they are an important source of care that Maryland will likely need to draw on even as more Marylanders are insured. Without funding during the transition period, these safety net providers may not be able to sustain efforts until private sector capacity is demonstrated.

Health reform includes a number of investments in safety net programs. The ACA authorizes $11 billion to fund community health centers. There is an opportunity to improve collaboration so that Maryland communities effectively compete for new funds and efficiently use current resources. Maryland's diverse network of safety net providers today have to compete for scarce resources. With collaboration and strategic planning, safety net providers can work together to meet the challenge of health care reform. There was discussion of a strategic plan that integrates and coordinates the work of LHDs, community health centers, school-based health centers, faith-based safety net providers, other safety net providers and community-based organizations. Some jurisdictions may not have these providers, and it was suggested that all providers participate in the strategic planning effort. These local strategic plans would help identify critical gaps in health care services, foster collaborations with the private sector to fill those gaps, and identify those services which continue to be unmet where public providers must fill the gap.

Some comments suggested that Maryland should address through regulation or statute the current barriers for LHDs to contract with private insurers and bill allowable costs to Medicaid Managed Care Organizations (MCOs), commercial payers, and the Primary Adult Care (PAC) program, if eligible. The rationale for this comment was that is some areas LHDs are the only providers or are necessary because the private sector capacity is not adequate to serve the need for substance abuse treatment. Other comments recognized that some individuals are likely to transition in and out of Medicaid and Exchange products and that all types of safety net providers, including LHDs, need to be able to participate with Medicaid or other commercial products to maintain continuity of care.

Behavioral Health

National estimates are that one in five individuals has a behavioral health need. (President's New Freedom Commission on Mental Health, May 2003) Of all disability groups, individuals with mental health problems reported the highest rates of lack of health insurance. The implementation of health reform has implications for how behavioral health services are provided and how care is ultimately received by those with need. Health reform expands the number of individuals that have health insurance and will mean that Medicaid and commercial insurance will have a bigger role in financing mental health and substance abuse treatment services.

The ACA requires the federal government to develop Essential Health Benefits. These Essential Health Benefits must include behavioral health services and must be offered by all health plans participating in the Health Insurance Exchange. States may require benefits in addition to the Essential Health Benefits but must also pay the marginal cost for these additional benefits. As such, this federal decision is critically important to which benefits will be covered by health insurance and how they will be financed. To date, there has been little guidance from the federal government on when these decisions will be made and which benefits may be included or excluded. Some comments recognized Maryland as a leader in mental health coverage and urged the State to advocate to the federal government to ensure mental health coverage in the Essential Health Benefits. Further, comments suggested that Maryland's public mental health system should maintain behavioral health services at existing levels if the level of behavioral health coverage mandated by the federal government in the Essential Benefit Package is less than what is currently required in Maryland. Other benefit and coverage issues identified focused on the use of Addiction Medicine Patient Placement (ASAM) Criteria. Medicaid MCOs are required to use ASAM criteria when determining the appropriate level of care for individuals seeking alcohol and drug addiction treatment. Comments urged that Maryland mandate the use of ASAM by all payers, including insurance products offered through the Exchange.

Maryland's current Public Mental Health System was described by some commenters as one of the best in the nation. Maryland's Public Mental Health System is largely financed by Medicaid through a carve-out administered by an Administrative Services Organization. Attributes that were sited were its comprehensiveness and the growing use of evidence-based practice. These comments suggested that Maryland preserve and strengthen the current system. Another comment suggested health reform presents an opportunity to reevaluate its current system citing the current carve out of mental health services as an example of the fragmentation that exists in the system. This comment suggested an approach that would move mental health into a more coordinated structure with substance abuse disorders and other health care services.

There was consensus that behavioral health care services should be integrated and coordinated with somatic services at the point of delivery for the patient. This means that Maryland's delivery system should have a greater capacity to treat individuals with co-occurring mental

health and substance abuse treatment disorders, and somatic services should be effectively coordinated with behavioral health services.

The need to strengthen regulatory oversight and compliance functions were raised in the workgroup as it related to individuals with behavioral health care needs as well as other special populations. The complaint procedures for commercial and Medicaid MCOs were described as barriers rather than sincere efforts to resolve concerns. Suggestions were made to conduct a thorough review and audit of all government-administered quality and oversight functions so that duplicative and inefficient programs could be eliminated and cost effective mechanisms that ensure proactive complaint resolution could be identified. Other comments recommended that resources at the Maryland Insurance Administration, Office of Health Care Quality, Alcohol and Drug Abuse Administration (ADAA) and Mental Hygiene Administration be increased to address their regulatory oversight.

Several fiscal issues were raised by comments. First, one comment called for no less than the current funding for ADAA regardless of an increase in the number of insured individuals. This recommendation was made because there are likely to remain uninsured individuals who are seeking treatment and many services to support recovery (e.g., residential services, housing supports, continuing care, and some prevention services) which are often unreimburseable by Medicaid and commercial insurance. Second, others said the budget for the public mental health system should reflect the inevitable growth in new users of the system as a result of more individuals gaining coverage. Third, comments called on the State to invest in community-based mental health services citing the alternative as costly hospital care. Finally, assuring adequate reimbursement for behavioral health providers was cited as an issue.

Past experience has demonstrated that individuals enrolled in Medicaid churn in and out of coverage as their financial circumstances as well other factors change. This issue is particularly important for special populations to ensure continuity of care during critical transitions. Several comments focused on the need to ensure coordination of coverage and care for individuals with behavioral health needs who are transitioning out of jail. Re-entry programs that support efforts to fill the gaps in services are needed. Additionally, the fact that Medicaid individuals who are incarcerated lose their Medicaid eligibility, rather than having their coverage suspended, was cited as a barrier to effective re-entry efforts.

Special Populations

Health care reform will make health insurance available to many currently uninsured Marylanders. For many special populations, the ACA will create new opportunities to get health insurance. For others who already are covered, a comprehensive approach to implementation holds the potential to improve their access to care and their outcomes. Establishing available and affordable services is necessary but not sufficient to ensure that special populations who confront

a myriad of personal, socio-cultural, and logistical barriers receive the care they need. Experience shows that traditional delivery models may not reach some populations.

The term "special populations" is broad. Comments suggested that the State needs the capability to identify those populations at highest risk for difficulty in accessing affordable, high quality care. Many different groups of individuals, both insured and uninsured, were identified through comments as special populations. Insurance status, immigration status, employment status, socioeconomic status, health status, disability status, age, English language proficiency, housing status, involvement with the criminal justice system, and health literacy level are all factors which potentially contribute to risk for barriers to access. Concerns were raised that the State should include in its definition of special populations those individuals not traditionally recognized by public programs, including undocumented persons, persons who are homeless, farm workers and other migratory workers in agricultural and non-agricultural jobs, racial and ethnic minorities, and recent immigrants.

Health reform implementation should address the barriers to care that some special populations face, including issues that affect access to care, language and literacy issues, cost issues and continuity of care. Some comments called for an evaluation of existing and new provider networks to see if they adequately meet the needs of adults and children with disabilities.

Other Issues

Some comments related to Medicaid reimbursement. Some said that annual updates should reflect the full inflation-driven cost of providing care. Others related to Hospital Averted Uncompensated Care, expressing concern with the averted uncompensated care assessment. They called for the current prospective reductions in hospital payments to end until all prior averted uncompensated care reconciliations have been completed to the satisfaction of policymakers and reconciled with actual hospital experience. Others called for Medicaid and MCHP reimbursement rates to be increased to incentivize physician participation in these programs because they are important vehicles for expansion.

Other comments said the State should consider incrementally expanding Medicaid for single, childless adults before the 2014 federal requirement. This expansion would begin to integrate special populations into health insurance and end the lengthy disability determination process for many individuals. Other perspectives were that Maryland should not expand Medicaid early because if funding is available a higher priority would be to restore Medicaid cuts.

A suggestion was made to create a commission or taskforce to address the ethical issues that may be generated by reform implementation. These issues include problems of confidentiality that may arise from a greater use of technology, informed consent, client self-determination, and conflict of duties for professionals.

Immediate Issues

The workgroup was directed by the HCRCC to focus on issues that require immediate attention. These are issues that require action in 2011 or that lay the ground work for future efforts. Many of the critical issues to the safety net depend on other State implementation decisions or the outcome of federal decisions on Essential Health Benefits which are not likely to occur in the immediate future. The ACA does not require State action on issues discussed by the workgroup, but careful planning to prepare for the changes ACA should begin immediately.

Options

The workgroup participants discussed a number of strategies for consideration in health reform implementation. Some of the options presented here are a melding of different suggestions received that relate to public health, safety net and special populations – the areas of focus for this workgroup. Although the options are divided into different categories, the workgroup recognized there is significant overlap between them and should be considered together.

Underlying these options were several general areas of consensus.

Areas of Consensus

1. Health insurance coverage is necessary, but not sufficient to improve health outcomes. Health care reform is an opportunity to embrace a "culture of care" where not only do individuals have health insurance, but are also able to access to health care services. Maryland heath reform implementation efforts should recognize that some individuals may not be able to access the health care for reasons such as racial or ethnic disparities, geographic, cultural, or linguistic barriers and/or provider shortages. Achieving a culture of care requires that these issues are addressed.
2. Maryland should maintain support for safety net programs because some individuals will continue to be uninsured or may have needs that are not met by their health insurance.
3. Continuity of care is particularly important for special populations. Some individuals are likely to transition in and out of Medicaid and Exchange plans and may have periods when they are uninsured. Assuring continuity of care requires that a safety net continues to exist and that it is fully integrated to Medicaid and Exchange plans.
4. There is an opportunity to improve the coordination and delivery of care for uninsured individuals.
5. The traditional business model and operating practices of some safety net providers may need to change to take full advantage of the opportunities of reform.
6. There is an opportunity for Maryland to improve collaboration between public and safety net providers to effectively compete for new funds and efficiently use current resources.

7. Federal decisions on Essential Health Benefits will be critically important. Maryland may need to maintain funding for services excluded from this definition. Comprehensive benefits are particularly important for individuals covered by Medicaid.
8. Behavioral health services should be integrated and coordinated to improve patient care.
9. The public health infrastructure, including LHDs, and population-based health programs provide unique functions that will need to continue following reform implementation.
10. Health reform implementation should address the barriers to care that some special populations may face.

Public Health

1. State Health Improvement Plan - The State should work collaboratively with LHDs and other partners to develop a statewide heath improvement plan (SHIP), based on a data-driven state health needs assessment. The plan should identify statewide health priorities, with corresponding quantitative indicators of both baseline and future targets, which can be monitored at the State and local level to track performance and support continuous quality improvement processes. These indicators and benchmarks should include state goals for health status, access to quality health services, provider capacity, consumer concerns and health equity. The SHIP should also indicate public and private sector partners that will work with state and LHDs on implementation of the SHIP. The plan developed should also include identification of gaps and barriers to plan implementation, areas of responsibility, evaluation, and a funding strategy that supports and sustains the work outlined in the plan. In addition, the State should explore approaches other states have used to fund statewide and local public health initiatives.

2. Local Implementation Plans - Local Health Departments should lead the development of Local Implementation Plans in collaboration with safety net providers, community health centers, hospitals, and other community based organizations. The goal of the Local Implementation Plan should be to ensure local achievement of SHIP goals for health status, health services, provider capacity, consumer concerns, and health equity by way of local collaboration and planning. The Community Health Resources Commission could provide technical assistance in local implementation planning, pilot models of local implementation planning in a few jurisdictions, and work to resolve implementation barriers identified by local planning groups. The Local Implementation Plan could identify issues which should be addressed in the statewide plan or through other statewide efforts.

3. Pursue ACA funding opportunities to modernize the health IT systems at both the state and local level and provide on-going technical and other supports to fully integrate community-based prevention and public health projects. Funding may be available

through the Prevention and Public Health Fund and Community Transformation Grant Program.

Safety Net

4. Access for uninsured: Once more information is known about the federal benefit package, a plan for coordination of safety net services should be developed. This plan should address how to facilitate enrollment in health insurance for those who are eligible as well as coordinate the follow-up care for those who remain uninsured.

5. Preparing Safety Net Providers for Opportunities of Reform
    a. Technical Assistance - The State should assist safety net providers prepare for the changes that may result from reform. Further consideration should be given to whether common administrative systems and technical assistance would be successful in helping small safety net providers to contract with Medicaid and commercial insurers and be reimbursed by these third party payers. The Maryland Community Health Resources Commission is capable and well positioned to provide this assistance. A plan could assess the administrative infrastructure of small safety net providers, identify opportunities to partner to more efficiently support these activities, and develop a business plan for the sustainability of these efforts.

    b. Local Health Department Contracting – In the event that there is no private capacity to provide clinical services in some areas of the State, LHDs should be able to effectively finance gap filling services. Further, LHDs should have the flexibility required to enter into innovative partnerships, such as contributing to patient- centered medical homes, in order to improve local service delivery. Currently, there are certain statutory and administrative barriers to the contracting with private entities that impede innovation and efficiency. These barriers should be removed to fully leverage opportunities for public-private partnerships to improve health.

Behavioral Health

6. Study the integration of mental health, substance abuse treatment and somatic services – The State should study different strategies to achieve the integration of mental health, substance abuse treatment and somatic services to a greater extent than was achievable through the workgroup. The study should address the statewide administrative structure, policy, and budget necessary to encourage coordination of care; the local resource planning activities needed to encourage collaboration; and the delivery system changes that can improve coordination and patient care.

Special Populations

7. Oversight Assessment - The State should conduct an assessment of how government administered quality and oversight functions work for special populations, such as individuals with behavioral health needs. In the workgroup's three meetings, this option was not fully developed and more work would need to be done to understand the implementation and cost issues.

Further, the workgroup recognized the public health, safety net, behavioral health, racial and ethnic disparities, and special populations are all key components of health reform and should be considered in all health reform implementation activities. The workgroup developed a list of implementation considerations (see Table 1) for other workgroups. These cross cutting issues were identified through comments from workgroup participants, but were not discussed in detail by the workgroup. These considerations should be considered and evaluated by organizations implementing different aspects of reform, and the wide range of organizations representing special populations should participate in the resolution of these issues as reform implementation progresses to more detailed issues.

Table 1. Considerations for Other HCRCC Workgroups and Reform Implementation Activities
Entry into Coverage Workgroup
• Facilitating entry into coverage is essential • System needs the capability to suspend coverage for those transitioning in and out of institutional settings • Eligibility for Medicaid, MCHP, Exchange and social service programs should be integrated. • Use community based organizations to facilitate enrollment. • Current enrollment practices, procedures and infrastructure should be examined and improved to meet the expanded needs by both individuals seeking coverage and for the entities responsible for eligibility determination. • Processes should be streamlined into a consumer friendly eligibility model and expedited to allow for seamless enrollment, re-enrollment, or for those that have a change in eligibility status.
Health Care Workforce Workgroup
• Conduct a needs assessment of behavioral health workforce capacity and develop a plan in conjunction with behavioral health community to mitigate shortages • Increase the network of health care providers through visiting physicians, advanced practice nurses, and partnerships though higher education in the context of reaching the developmental disability community • Create opportunities for better continuing education and training to medical providers to better understand the needs of developmental disability community, including informed consent and medical decision-making • The State should consider funding through ACA to support the Primary Extension Care Center, which provides funding for states to develop primary care learning communities to support community health teams • Incentivize more providers to participate in Medicaid, including specialists. • Expand role of nurses and physician assistance in primary care • Better compensation for primary care is needed
Health Care Delivery System Workgroup
• Behavioral health providers should be considered as Medical home • Emergency room visits provide opportunity for brief screening tool for substance abuse disorders and provider education about tools and referrals is needed • Create more capacity to treat individuals with co-occurring disorders • Better coordinate services between primary care providers and specialists • Facilitate the establishment of nurse-managed health centers at locations with concentrations of vulnerable populations • Explore collaborative agreements between primary care and specialists where majority of care is provided by primary care physicians and telemedicine and telehealth strategies used for specialists to review and consult with primary care providers • Facilitate the establishment of nurse-managed health centers at locations with concentrations of vulnerable populations • Explore collaborative agreements between primary care and specialists where majority of care is provided by primary care physicians and telemedicine and telehealth strategies used for specialists to review and consult with primary care providers

- Unleash the potential of nursing workforce to serve as part of safety net by removing current barriers, e.g., collaborative agreements and attestations, reimbursement parity, advocacy for federal Medicare reimbursement for reimbursement of home care by specified advanced practice nurses and physician assistants
- Local health department staffing needs also should be included in any examination of health care workforce issues. If local health departments move out of direct service provision, they will lose the infrastructure that is needed for emergency response and the wrap-around services that are necessary in a public health emergency. The staff that remains will require additional training and support in order to carry out the local health department functions

Education and Outreach Workgroup

- Public education is needed for individuals not currently covered understand the benefits
- Public education on mental health parity needed

- If the new system is to work and special populations are to be reached greater emphasis must be placed on educating the citizenry on the upcoming changes and how they will impact health care delivery in the future

- Health literacy should be adopted as a principle in all health reform efforts

Exchange and Insurance Markets Workgroup

- There should be a State subsidy for individuals with income between 133%-200% FPL in the Exchange
- Evaluate new and existing provider networks to see if they meet the needs of adults and children with disabilities
- Broaden coverage in Exchange to include individuals over age 65 who are not enrolled in Medicare
- Exchange should coordinate with Medicare to meet the needs of Maryland seniors

Long-Term Care

- Community First – focus on the follow-up and services necessary to keep individuals out of nursing homes and in their home
- Shift Maryland's long-term care program to more community-based care
- Integration of long-term care and health care should be a goal
- CLASS Act – Maryland should evaluate the potential to provide assistance for CLASS premiums below a certain income to increase uptake
- Also consider whether it would be cost effective to use State funds to buy-in some individuals to CLASS

Other

- Nurse informaticians should be a part of Health Information Exchange
- Public health surveillance and monitoring of diseases and health conditions should be integrated into Statewide and regional health information exchange
- Local Health Departments should be integrated into Maryland's Health Information Exchange and receive sustainable funding to do so.